rate request filings have been completed.

(i) If federal financial participation to match the assessment is not approved for the initial implementation of a state plan amendment, the assessment and all other provisions contained in this section will not be implemented. If federal financial participation to match the assessment becomes unavailable under federal law after the implementation date, the authority to impose the assessment terminates on the date that the federal statutory, regulatory, or interpretive change takes place, and such termination will apply prospectively. In addition, prospective termination of the assessment as described in this subsection will result in the prospective termination of any rate increases created by the provisions of this section on that same date.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-24)

Rule 17. Rate-Setting Criteria for State-Owned Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

405 IAC 1-17-1 Policy; scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15; IC 24-4.6-1-101

Sec. 1. (a) This rule sets forth procedures for payment for services rendered to Medicaid recipients by duly certified, state-owned intermediate care facilities for the mentally retarded (ICF/MR). All payments referred to within this rule for the provider groups and levels of care are contingent upon the following:

(1) Proper and current certification.

(2) Compliance with applicable state and federal statutes and regulations.

(b) The procedures described in this rule set forth methods of reimbursement that promote quality of care, efficiency, economy, and consistency. These procedures recognize level and quality of care, establish effective accountability over Medicaid expenditures, provide for a regular review mechanism for rate changes, compensate providers for reasonable, allowable costs incurred by a prudent businessperson, and allow incentives to encourage efficient and economic operations. The system of payment outlined in this rule is a prospective system predicated on a reasonable, cost-related basis. Cost limitations are contained in this rule which establish parameters regarding the allowability of costs and define reasonable allowable costs.

(c) Retroactive repayment will be required by providers when an audit verifies overpayment due to discounting, intentional misrepresentation, billing or payment errors, or misstatement of historical financial or historical statistical data which caused a rate higher than would have been allowed had the data been true and accurate. Upon discovery that a provider has received overpayment of a Medicaid claim from the office, the provider must complete the appropriate Medicaid billing adjustment form and reimburse the office for the amount of the overpayment.

(d) The office may implement Medicaid rates prospectively without awaiting the outcome of the administrative appeal process. However, any action by the office to recover an overpayment from previous rate reimbursements, either through deductions of future payments or otherwise, shall await the completion of the provider's administrative appeal within the office, providing the provider avails itself of the opportunity to make such an appeal. Interest shall be assessed in accordance with IC 12-15-13-3)

405 IAC 1-17-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) As used in this rule, "all-inclusive rate" means a per diem rate which, at a minimum, reimburses for all nursing care, room and board, supplies, and ancillary therapy services within a single, comprehensive amount.

(b) As used in this rule, "annual, historical or budget financial report" refers to a presentation of financial data,

including accompanying notes, derived from accounting records and intended to communicate the provider's economic resources or obligations at a point in time, or the changes therein for a period of time in compliance with the reporting requirements of this rule which shall constitute a comprehensive basis of accounting.

(c) As used in this rule, "budgeted/forecasted data" means financial and statistical information that presents, to the best of the provider's knowledge and belief, the expected results of operation during the rate period.

(d) As used in this rule, "cost center" means a cost category delineated by cost reporting forms prescribed by the office.

(e) As used in this rule, "office" means the Office of Medicaid Policy and Planning.

(f) As used in this rule, "desk audit" means a review of a written audit report and its supporting documents by a qualified auditor, together with the auditor's written findings and recommendations.

(g) As used in this rule, "field audit" means a formal official verification and methodical examination and review, including the final written report of the examination of original books of accounts by auditors.

(h) As used in this rule, "forms prescribed by the office" means forms provided by the office or substitute forms which have received prior written approval by the office.

(i) As used in this rule, "general line personnel" means management personnel above the department head level who perform a policy making or supervisory function impacting directly on the operation of the facility.

(j) As used in this rule, "generally accepted accounting principles" means those accounting principles as established by the American Institute of Certified Public Accountants.

(k) As used in this rule, "ICF/MR" means intermediate care facilities for the mentally retarded.

(l) As used in this rule, "like levels of care" means care provided in a state-operated ICF/MR;

(m) As used in this rule, "market area limitation (MAL)" means a rate ceiling for all Medicaid rates established by the office that is calculated on allowable costs using forecasted data submitted by providers when requesting rate review.

(n) As used in this rule, "ordinary patient related costs" means costs of services and supplies that are necessary in delivery of patient care by similar providers within the state.

(o) As used in this rule, "patient/recipient care" means those Medicaid program services delivered to a Medicaid enrolled recipient by a certified Medicaid provider.

(p) As used in this rule, "reasonable allowable costs" means the price a prudent, cost conscious buyer would pay a willing seller for goods or services in an arms length transaction, not to exceed the limitations set out in this rule.

(q) As used in this rule, "unit of service" means all patient care at the appropriate skill level included in the established per diem rate required for the care of an inpatient for one (1) day (twenty-four (24) hours).

405 IAC 1-17-3 Accounting records; retention schedule; audit trail; cash basis; segregation of accounts by nature of business and by location

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 3. (a) The basis of accounting used under this rule is a comprehensive basis of accounting other than generally accepted accounting principles. However, generally accepted accounting principles shall be followed in the preparation and presentation of all financial reports and all reports detailing proposed change of provider transactions unless otherwise prescribed by this rule.

(b) Each provider must maintain financial records for a period of three (3) years after the date of submission of financial reports to the office. The cash basis of accounting shall be used in all data submitted to the office. The provider's accounting records must establish an audit trail from those records to the financial reports submitted to the office.

(c) In the event that a field audit visit indicates that the provider's records are inadequate to support data submitted to the office, and the auditor is unable to complete the audit and issue an opinion, the provider shall be given, in writing, a list of the deficiencies and allowed sixty (60) days from the date of receipt of this notice to correct the deficiencies. In the event the deficiencies are not corrected within the sixty (60) day period, the office shall not grant any rate increase to the provider until the cited deficiencies are corrected and certified to the office by the provider. However, the office may:
(1) make appropriate adjustments to the applicable cost reports of the provider resulting from inadequate records;
(2) document such adjustments in a finalized exception report; and
(3) incorporate such adjustments in prospective rate calculations under section 1(d) of this rule.

(d) If a provider has business enterprises other than those reimbursed by Medicaid under this rule, the revenues, expenses, and statistical and financial records for such enterprises shall be clearly identifiable from the records of the operations reimbursed by Medicaid. If a field audit establishes that records are not maintained so as to clearly identify Medicaid information, none of the commingled costs shall be recognized as Medicaid allowable costs and the provider's rate shall be adjusted to reflect the disallowance effective as of the date of the most recent rate change.

(e) When multiple facilities or operations are owned by a single entity with a central office, the central office records shall be maintained as a separate set of records with costs and revenues separately identified and appropriately allocated to individual facilities. Each central office entity shall file an annual financial report and budget financial report coincidental with the time period for any type of rate review for any individual facility that receives any central office allocation. Allocation of central office costs shall be reasonable, conform to generally accepted accounting principles, and be consistent between years. Any change of central office allocation bases must be approved by the office prior to the changes being implemented. Proposed changes in allocation methods must be submitted to the office at least ninety (90) days prior to the reporting period to which the change applies. Such costs are allowable only to the extent that the central office is providing services related to patient care and the provider can demonstrate that the central office costs improved efficiency, economy, or quality of recipient care. The burden of demonstrating that costs are patient related lies with the provider.

405 IAC 1-17-4 Financial report to office; annual schedule; prescribed form; extensions; penalty for untimely filing

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than ninety (90) days after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report.

(b) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

(1) Patient census data.
(2) Statistical data.
(3) Ownership and related party information.
(4) Statement of all expenses and all income.
(5) Detail of fixed assets and patient related interest bearing debt.
(6) Schedule of Medicaid and private pay charges; private pay charges shall be lowest usual and ordinary charge on the last day of the reporting period.

(7) Certification by the provider that the data are true, accurate, related to patient care, and that expenses not related to patient care have been clearly identified.
(8) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

(c) Extension of the ninety (90) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request for extension and notify the provider of approval or disapproval within ten (10) days of receipt. If the request for extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(d) Failure to submit an annual financial report in the time limit required shall result in the following actions:
(1) No rate review requests shall be accepted or acted upon by the office until the delinquent report is received.
(2) When an annual financial report is thirty (30) days past due, and an extension has not been granted, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the month following the thirtieth day the annual financial report is past due, and shall so remain until the first day of the month after the delinquent annual financial report is received by the office. Reimbursement lost because of the penalty cannot be recovered by the provider.

405 IAC 1-17-5 New provider; initial financial report to office; criteria for establishing initial interim rates; supplemental report; base rate setting

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 5. (a) Rate requests to establish initial interim rates for a new operation or a new type of certified service shall be filed by completing the budget financial report form and submitting it to the office on or before thirty (30) days after notification of the certification date or establishment of a new service or new operation. The budget financial report shall reflect the forecasted data of operating for the first twelve (12) months and shall be subject to appropriate reasonableness tests. Initial interim rates shall be effective upon certification, or the date that a service is established, whichever is later.

(b) The methodology, set out in this rule, used to compute rates for active providers shall be followed to compute initial interim rates for new providers, except that historical data are not available.

(c) Since an initial interim rate is established based upon forecasted financial data only, the provider shall file a nine (9) month financial report within sixty (60) days following the end of the first nine (9) months of operation, together with forecasted data for twelve (12) months of operation. This twelve (12) month period of forecasted data shall start on the first day of the tenth month of certified operation of the facility. The nine (9) months of historical financial data and the twelve (12) months of forecasted data shall be used to determine the provider's base rate. The base rate shall be effective from the first day of the tenth month of certified operation until the next regularly scheduled annual review. An annual financial report need not be submitted until the provider's first fiscal year end that occurs after the rate effective date of a base rate. In determining the base rate, limitations and restrictions otherwise outlined in this rule, except the annual rate limitation, shall apply. For purposes of this subsection, in determining the nine (9) months of the historical financial report, if the first day of certification falls on or before the fifteenth day of a calendar month, then that calendar month shall be considered the provider's first month of operation. If the first day of certification falls after the fifteenth day of a calendar month, then the immediately succeeding calendar month shall be considered the provider's first month of certified operation.

(d) The base rate may be in effect for longer or shorter than twelve (12) months of forecasted data. In such cases, the various applicable limitations shall be proportionately increased or decreased to cover the actual time frame, using a twelve (12) month period as the basis for the computation.

(e) Extension of the sixty (60) day filing period shall not be granted unless the provider substantiates to the office circumstances that preclude a timely filing. Requests for extensions shall be submitted to the office, prior to the date due, with full and complete explanation of the reasons an extension is necessary. The office shall review the request and notify the provider of approval or disapproval within ten (10) days of receipt. If the extension is disapproved, the report shall be due twenty (20) days from the date of receipt of the disapproval from the office.

(f) In the event the provider fails to submit nine (9) months of historical financial data and the twelve (12) months of forecasted data as required in subsection (c), the following action shall be taken. When submission of the nine (9) months of historical financial data and the twelve (12) months of forecasted data is thirty (30) days past due, and an extension has not been granted, the initial rate shall be reduced by ten percent (10%), effective on the first day of the tenth month after certification and shall so remain until the first day of the month after receipt of the report by the office.

405 IAC 1-17-6 Active providers; rate review; annual request; additional requests; requests due to change in law

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 6. (a) As a normal practice, rates shall be reviewed once each year using the annual financial report as the basis of the review. The rate effective date shall be the first day of the fourth month following the provider's reporting year end, provided the annual financial report is submitted within ninety (90) days of the end of the provider's reporting period. If the provider requests that the rate be reviewed, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be prepared by the provider and submitted with the annual financial report.

(b) A provider shall not be granted an additional rate review until the review indicated in subsection (a) has been completed. A provider may request no more than one (1) additional rate review during its budget reporting year when the provider can reasonably demonstrate the need for a change in rate based on more recent historical and forecasted data. This additional rate review shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place.

(c) To request the additional review, the provider shall submit, on forms prescribed by the office, a minimum of six (6) months of historical data of which at least four (4) months must be subsequent to the fiscal year end of the annual financial report. In addition, a budget financial report covering the twelve (12) month period immediately following the expected rate effective date shall be submitted. Any new rate resulting from this additional review shall be effective on the first day of the month following the submission of data to the office.

(d) The office may consider changes in federal or state law or regulation during a calendar year to determine whether a significant rate increase is mandated. This review will be considered separately by the office, and will not be considered as an additional rate review.

405 IAC 1-17-7 Request for rate review; budget component; occupancy level assumptions; effect of inflation assumptions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 7. Under this rate setting system, emphasis is placed on proper planning, budgeting, and cost control by the provider. To establish consistency in the submission and review of forecasted costs, the following apply:

(1) Each rate review request shall include a budget financial report. If a budget financial report is not submitted, the rate review will not result in an increase in Medicaid rates, but may result in a rate decrease based on historical or annual financial reports submitted.

(2) All budget financial reports shall be submitted using forms prescribed by the office. All forecasted data and required attachments shall be completed to provide full financial disclosure and will include as a minimum the following:

(A) Patient census data.

(B) Statistical data.

(C) Ownership and related party information.
(D) Statement of all expenses and all income.
(E) Detail of fixed assets and patient related interest bearing debt.
(F) Schedule of Medicaid and private pay charges; charges shall be the lowest usual and ordinary charge on the rate effective date of the rate review.
(G) Certification by the provider that forecasted data has been prepared in good faith, with appropriate care by qualified personnel, using appropriate accounting principles and assumptions, and that the process to develop the forecasted data uses the best information that is reasonably available and is consistent with the plans of the provider. The certification shall state that all expenses not related to patient care have been clearly identified or removed.
(H) Certification by the preparer, if the preparer is different from the provider, that the forecasted data were compiled from all information provided to the preparer and that the preparer has read the forecasted data with its summaries of significant assumptions and accounting policies and has considered them to be not obviously inappropriate.

(3) Forecasted data shall be based on a census figure of not less than eighty percent (80%). The provider shall adjust patient census data based on the highest of the following:
(A) Eighty percent (80%) of bed days available. Budget financial reports submitted to the office at less than eighty percent (80%) occupancy will not be considered as meeting the filing requirements of this section.
(B) Historical patient days for the most recent historical period, unless the provider can justify the use of a lower figure for the patient days.
(C) Forecasted patient days for the twelve (12) month budget period.

(4) The provider and the office shall recognize and adjust forecasted data accordingly for the inflationary or deflationary effect on historical data for the period between the midpoint of the historical or annual financial report time period and the midpoint of the budget financial report. Forecasted data may be adjusted based upon reasonably anticipated rates of inflation.

405 IAC 1-17-8 Limitations or qualifications to Medicaid reimbursement; advertising; vehicle basis

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 8. Advertising is not an allowable cost under this rule except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements. Advertising costs are not allowable in connection with public relations, fundraising, or to encourage patient utilization.

405 IAC 1-17-9 Criteria limiting rate adjustment granted by office

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 9. The Medicaid reimbursement system is based on recognition of the provider's allowable costs. The payment rate is subject to several limitations. Rates will be established at the lowest of the four (4) limitations listed as follows:
(1) A market area limitation (MAL) applies to all providers covered by this rule. The limitation shall be computed on a statewide basis using forecasted data submitted by providers for rate reviews. The market area limitation is an

amount which shall be one hundred thirty percent (130%) of the average allowable cost, weighted by beds that are designated for like levels of care. The average allowable cost for like levels of care shall be maintained by the office, and a revision shall be made to this rate limitation four (4) times per year effective on March 1, June 1, September 1, and December 1.

(2) The calculated rate is the sum of the allowed per diem costs.

(3) In no instance shall the approved Medicaid rate be higher than the rate paid to that provider by the general public for the same type of services.

(4) Should the rate calculations produce a rate higher than the reimbursement rate requested by the provider, the approved rate shall be the rate requested by the provider.

405 IAC 1-17-10 Computation of rate; allowable costs; review of cost reasonableness

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 10. (a) The rate for a room with two (2) beds, which is the basic per diem room rate, shall be established as a ratio between total allowable costs and patient days, subject to all other limitations described in this rule.

(b) Costs and revenues shall be reported as required on the financial report forms. Patient care costs shall be clearly identified.

(c) The provider shall report as patient care costs only costs that have been incurred in the providing of patient care services. The provider shall certify on all financial reports that costs not related to patient care have been separately identified on the financial report.

(d) In determining reasonableness of costs, the office may compare line items, cost centers, or total costs of providers with like levels of care in the same geographic area. The office may request satisfactory documentation from providers whose costs do not appear to be reasonable.

405 IAC 1-17-11 Allowable costs; capital reimbursement; depreciable life

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 11. (a) Providers shall be reimbursed for the use of facilities and equipment, regardless of whether they are owned or leased. Such reimbursement shall include all depreciation, interest, lease, rent, or other consideration paid for the use of property. This includes all central office facilities and equipment whose patient care-related depreciation, interest, or lease expense is allocated to the facility.

(b) The straight line method will be used to calculate the allowance for depreciation. For depreciation purposes, the following will be used:

Property	Depreciable Life
Land improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

405 IAC 1-17-12 Capital reimbursement; basis; historical cost; mandatory record keeping; valuation

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 12. (a) The basis used in computing the capital reimbursement shall be the historical cost of all assets used to deliver patient related services, provided the following:

(1) They are in use.
(2) They are identifiable to patient care.
(3) They are available for physical inspection.
(4) They are recorded in provider records.

If an asset does not meet all of the requirements prescribed in this section, the cost shall not be included in computing the reimbursement.

(b) The provider shall maintain detailed property schedules to provide a permanent record of all historical costs and balances of facilities and equipment. Summaries of such schedules shall be submitted with each annual financial report, and the complete schedule shall be submitted to the office upon request.

(c) Assets used in computing capital reimbursement shall include only items currently used in providing services customarily provided to patients.

(d) When an asset is acquired by trading one (1) asset for another, or a betterment or improvement is acquired, the cost of the newly acquired asset, betterment, or improvement shall be added to the appropriate property category. All of the historical cost of the traded asset or replaced betterment or improvement shall be removed from the property category in which it was included.

(e) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least three (3) years and a historical cost of at least five hundred dollars ($500), the cost shall be included in the property basis for the approved useful life of the asset. Items that do not qualify under this subsection shall be expensed in the year acquired.

(f) The property basis of donated assets, except for donations between providers or related parties, shall be the fair market value defined as the price a prudent buyer would pay a seller in an arms length sale, or if over two thousand dollars ($2,000), the appraised value, whichever is lower. An asset is considered donated when the provider acquires the